AUTHORIZATION FOR RELEASE OF INFORMATION

YOUR INFORMATION		
Last Name:	First Name:	Middle Name:
Address:	City/State/Zip:	CDC/YA Number:

Person/Organization Providing the Information [45 C.F.R. § 164.508(c)(1)(ii) & Civ. Code § 56.11(e).]	Person/Organization to Receive the Information [45 C.F.R. § 164.508(c)(1)(iii) & Civ. Code § 56.11(f).]
CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION	

Description of the Information to be Released
(Provide a detailed description of the specific information to be released.)
[45 C.F.R. § 164.508(c)(1)(i) & Civ. Code §§ 56.11(d) & (g).]

- ☐ Medical
- ☐ HIV
- ☐ Genetic Testing
- ☐ Substance Abuse
- ☐ Mental Health
- ☐ Communicable Diseases

Additional Information:

_____

_____

_____

Description of Each Purpose for the Use or Release of the Information
(Provide a detailed description of the activity for which the information will be used)
[45 C.F.R. § 164.508(c)(1)(iv).]

_____

_____

_____

Will the health plan or provider receive money for the release of this information?
[45 C.F.R. § 164.508(a)(3).]

NO, WITH THE EXCEPTION OF COPY COSTS.

This authorization for release of the above information to the above-named persons/organizations will expire on: _____ (date). [45 C.F.R. § 164.508(c)(1)(v) & Civ. Code § 56.11(h).]

I understand:

- **I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary. [45 C.F.R. § 164.508(c)(2)(i).]**
- **I have the right to revoke this authorization by sending a notice stopping this authorization to _____ at _____. The authorization will stop on the date my request is received. [45 C.F.R. § 164.508(c)(2)(i) & Civ. Code § 56.11(h).]**
- **I understand that I am signing this authorization voluntarily and that treatment, payment or eligibility for my benefits will not be affected if I do not sign this authorization. [45 C.F.R. § 164.508(c)(2)(ii).]**
- **I understand if the organization I have authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. [45 C.F.R. § 164.508(c)(2)(ii).]**
- **I understand I have the right to receive a copy of this authorization. [Civ. Code § 56.11(i).]**

Signature:	CDC/YA Number:	Date:

[45 C.F.R. § 164.508(c)(1)(vi) & Civ. Code § 56.11(c).]

Representative:	Relationship:	CDC/YA Number:	Date: